TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Memorial Hermann Specialty Hospital

Respondent Name
United Airlines

MFDR Tracking Number
M4-24-1110-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
January 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 11, 2023	C1713	$117.52	$117.51
July 11, 2023	L8699	$310.00	$310.00
July 11, 2023	29888	$85.60	$85.60
	Total	$513.12	$513.11

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a document titled "Reconsideration" dated January 3, 2024 that states, "According to TX Workers Compensation fee schedule the expected reimbursement for DOS 7/11/2023 is $13,262.90. Per Rule 134.402, implants should be reimbursed at manual cost plus 10%. Previous payment received totaled $12,749.78. Please remit payment for remaining balance due."

Amount in Dispute: $513.12

Respondent's Position

"…Respondent requests this dispute be dismissed since it involves network health care paid pursuant to a contract, not subject to disclosure."

Response submitted by Downs ♦ Stanford P.C.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.403 sets out the billing and reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 131 – Claim specific negotiated discount.
- 192 – Non standard adjustment code from paper remittance.
- 193 – Original payment decision is being maintained. Upon review, I was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3/350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- B13 – Re-evaluated. No additional payment is recommended.
- DY6 – Implant charges processed under separate cover through Foresight.
- PK6 – Subject to CHCWC/United Airlines TX HCN. A certified TX HCN.

Issues

1. Did the respondent support the injured network is enrolled in a certified healthcare network?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment for outpatient hospital services rendered in July of 2023. The insurance carrier paid the service but made a reduction stating the claim was

within the United Airlines TX HCN. Review of the submitted information and information known to the division found insufficient evidence to support the injured worker was enrolled in a certified network on the date of service. The insurance carrier's reduction is not supported. The disputed services will be reviewed per applicable fee guideline.

2. DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

DWC Rule 28 TAC §134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*.

The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Review of the submitted medical bill found a request for implants was made. The Medicare facility specific reimbursement amount will be multiplied by 130 percent.

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Procedure code 29888 has status indicator J1, for procedures paid at a comprehensive rate. This code is assigned APC 5114. The OPPS Addendum A rate is $6,614.63 multiplied by 60% for an unadjusted labor amount of $3,968.78, in turn multiplied by facility wage index 0.9925 for an adjusted labor amount of $3,939.01.
- The non-labor portion is 40% of the APC rate, or $2,645.85.
- The sum of the labor and non-labor portions is $6,584.86.
- The Medicare facility specific amount is $6,584.86 multiplied by 130% for a MAR of

$8,560.32. The submitted explanation of benefits dated September 8, 2023 indicates a payment of $8,474.72 via check 136801455.

Additionally, the requestor sought separate reimbursement of the implants rendered during surgery. Review of the submitted medical bill found the following items billed under Revenue Code 278.

- "Button Tightrope ABS 14m" as identified in the itemized statement and labeled on the invoice as "Tightrope ABS button round 14mm" with a cost per unit of $242.82;
- "Implant ACL Tightrope " as identified in the itemized statement and labeled on the invoice as "ACL TightRope with Fiber/tag" with a cost per unit of $569.10;
- "Implant ACL Tightrope " as identified in the itemized statement and labeled on the invoice as "ACL TightRope with Fiber/tag" with a cost per unit of $363.14;
- "Graft Achilles Tendon " as identified in the itemized statement and labeled on the invoice as "Ach Tndn" with a cost per unit of $3,100.00.

The total net invoice amount (exclusive of rebates and discounts) is $4,275.06. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $427.51. The total recommended reimbursement amount for the implantable items is $4,702.57. ForeSight made a payment of $4,275.06 on October 25, 2023 via check 0028809.

3. The total recommended reimbursement for the disputed services is $8,560.32 plus implant reimbursement of $4,702.57 equals total MAR of $13,262.89. The insurance carrier paid $12,749.78. The amount due is $513.11. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that United Airlines Inc must remit to requestor $513.11 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 24, 2024
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.